STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056155	A. Building B. Wing	03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Nursing and Rehabilitation Center	275 South Oak Avenue Oakdale, CA 95361

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure four of four sampled residents (Resident 5, Resident 15, Resident 56, Resident 76) were treated with respect and dignity when: 1.Resident 15's foley catheter bag (a collection bag that attaches to a foley catheter, a type of indwelling catheter [a catheter left in place for a period of time], to collect urine drained from the bladder) had urine visible from the hallway and was not covered with a foley catheter decency bag. This failure resulted in violating Resident 15's right to privacy. 2.Resident 5, Resident 56, and Resident 76 were lined up in the hallway outside of the dining hall and not allowed to enter and eat until other residents were done eating. This failure resulted in Resident 5, Resident 56 and Resident 76 being denied entry to the dining room and having to wait and watch other residents eat before they could be seated. Findings: 1.During a review of Resident 15's Admission Record (AR- document containing resident personal information), dated 3/20/25, the AR indicated, Resident 15 was admitted to the facility on [DATE] with diagnosis which included Parkinson's disease (chronic, progressive neurological disorder that affects movement, balance, and other bodily functions), muscle weakness and urinary incontinence (involuntary leakage of urine). During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/1/25, the MDS assessment indicated Resident 15's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 11 out of 15 which indicated Resident 15 had moderate cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2025
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/18/25 at 11:05 a.m. with Resident 15 in Resident 15's room, Resident 15's room door was open and next to the dining hall. Resident 15 was observed lying in bed with his foley catheter bag hanging on the right side of the bed with yellow liquid visible from the doorway. Resident 15 stated his room was on a busy corner. Resident 15 stated residents, staff and visitors frequently walked by his room to the dining hall. During an observation on 3/18/25 at 5:10 p.m. in Resident 15's room, Resident 15's room door was open. Resident 15 was observed lying in bed with his foley catheter bag hanging on the right side of the bed with yellow liquid visible from the doorway. During a concurrent observation and interview on 3/19/25 at 8:30 a.m. with Licensed Vocational Nurse (LVN) 5 in Resident 15's room, Resident 15 was observed lying in bed with his foley catheter bag hanging on the right side of the bed with yellow liquid visible from the doorway. LVN 5 stated urine was visible in the foley catheter bag and visible from the hallway. LVN 5 stated all resident's, staff and visitors that walked to the dining room saw Resident 15's foley catheter bag. LVN 5 stated Resident 15 was bed bound and could feel embarrassed. LVN 5 stated the foley catheter bag should be placed on the left side of the bed where it could not be seen from the hallway or covered with a foley decency bag. LVN 5 stated foley catheter decency bags were placed over foley catheter bags to obstruct view of urine in the foley catheter bag. LVN 5 stated foley catheter decency bags provided residents with privacy and dignity. During an interview on 3/20/25 at 4:51 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated it was expected to cover all foley catheter bags with a foley catheter decency bag when visible in a public area. CNA 7 stated foley catheter bags visible from the hallway with urine should be covered with a foley catheter decency bag. CNA 7 stated Resident 15's dignity and privacy were violated when his urine was visible form the hallway. During a concurrent interview and record review on 3/22/25 at 10:15 a.m. with the Director of Nursing (DON), Resident 15's Care Plan, dated 3/22/26, was reviewed. The DON stated she expected all foley catheter bags visible from the doorway to be covered with a foley catheter decency bag to maintain resident respect and dignity. The DON stated Resident 15's Care Plan required his foley catheter to be placed in a decency bag. The DON stated Resident 15's Care Plan was not followed. The DON stated Resident 15 was bedbound and on hospice services. The DON stated Resident 15 was moderately impaired and could not consistently make his needs known. The DON stated it was the responsibility of the facility to maintain Resident 15's dignity and privacy at the end of his life. The DON stated Resident 15's respect and dignity were violated when his foley catheter bag was visible from the doorway. During a review of the facility's policy and procedure (P&P) titled, Patients Rights and Responsibilities, dated 5/2023, the P&P indicated, .considerate and respectful care, and to be made comfortable. They have the right to respect .have personal privacy respected . 2.During a review of Resident 5's Admission Record (AR- document containing resident personal information), dated 3/20/25, the AR indicated, Resident 5 was admitted to the facility on [DATE] with diagnosis which included metachromatic leukodystrophy (a disorder that causes fatty substance to build up in cells and causes progressive loss of function), candidiasis (a fungal infection) of skin and nail, muscle weakness and left hand contracture (shortening and hardening of muscles, tendons, or other tissue leading to deformity and rigidity of joints). (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/1/25, the MDS assessment indicated Resident 5's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 00 out of 15 which indicated severe cognitive impairment (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a review of Resident 56's AR dated 3/20/25, the AR indicated, Resident 56 was admitted to the facility on [DATE] with diagnosis which included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.), Aspergers syndrome (A developmental disorder affecting ability to effectively socialize and communicate) and autistic disorder (eurological and developmental disorder that affects how people interact with others, communicate, learn, and behave.) During a review of Resident 56's MDS, dated [DATE], the MDS assessment indicated Resident 56's BIMS assessment score was 00 out of 15 which indicated severe cognitive impairment. During a review of Resident 76's AR dated 3/20/25, the AR indicated, Resident 76 was admitted to the facility on [DATE] with diagnosis which included hemiplegia (complete paralysis) and hemiparesis (partial or incomplete weakness) affecting left non-dominant side, muscle weakness, and dysphagia (trouble swallowing). During a review of Resident 76's MDS, dated [DATE], the MDS assessment indicated Resident 76's BIMS assessment score was 5 out of 15 which indicated Resident 76 had severe cognitive impairment. During an observation on 3/19/25 at 12:17 p.m. in the dining hall, six tables were observed. Three total residents were observed independently dining and eating their meals at separate tables. Kitchen staff delivered the last meal cart to nursing staff in the dining hall. Three tables had no residents seated at them and were clean. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/19/25 at 12:20 p.m. with Certified Nursing Assistant (CNA)2 in the dining hall, CNA 2 was observed brining Resident 76 into the dining hall. DSD 2 instructed CNA 2 not to enter the dining hall with Resident 76 until the three other independent feeder (residents who are able to feed themselves independently with no assistance) residents were done eating. CNA 2 was instructed by DSD 2 to line Resident 76 up in the hallway. Resident 5 and Resident 56 were observed lined up in the hallway by two staff members. DSD 2 instructed CNA 2 not to enter the dining hall with Resident 5 and Resident 56 until the three other independent feeder residents were done eating. CNA 2 stated Resident 5, Resident 56, and Resident 76 were not allowed into the dinning hall until the other three other independent feeder residents were done eating. Resident 76 yelled out, come on where's food. CNA 2 stated Resident 5, Resident 56, and Resident 76 had to wait in the hallway until the dining room was empty and the tables were cleaned. CNA 2 stated the three independent eaters in the dining hall needed to finish eating and their tables would need to be cleaned before Resident 5, Resident 56, and Resident 76 could enter and eat. CNA 2 stated Resident 5, Resident 56, and Resident 76 were all dependent feeders (residents who cannot feed themselves and require assistance to eat). CNA 2 stated dependent feeders needed total assist when eating and required one on one assistance. CNA 2 stated dependent feeders often had to wait extended periods of time to eat until independent feeders were done eating. CNA 2 stated she did not think it was right Resident 5, Resident 56, and Resident 76 had to wait outside the dining hall and watch the three independent feeders to finish their meal. CNA 2 stated Resident 5, Resident 56, and Resident 76 rights and dignity were violated when they had to wait outside the dining hall and watch three other residents finish their meal before they could enter. CNA 2 stated the facility had implemented different dining times for independent and dependent feeders for at least 2.5 years but could not state an exact date. During an observation on 3/19/25 at 12:28 p.m. Resident 5, Resident 56, and Resident 76 were brought into the dining hall, served their meals and assisted to eat. During an interview on 3/19/25 at 2:55 p.m. with the Registered Dietician (RD) 2, RD 2 stated she expected all meal trays to be served and fed at the same time. RD 2 stated independent feeders ate first, then the dining hall was cleaned, and then dependent feeders were allowed to enter and eat. RD 2 stated Resident 5, Resident 56, and Resident 76 should not have been lined up in the hallway outside of the dining hall and not allowed to enter and eat with the independent eaters. RD 2 could not state how dining schedules were determined and why independent feeders ate first. RD 2 stated Resident 5, Resident 56, and Resident 76 dignity were violated. RD 2 stated all residents had a right to eat at the same time regardless of dining capabilities. During an interview on 3/20/25 at 8:40 a.m. with Resident 76 in Resident 76's room, Resident 76 stated he had been at the facility for a while, but could not state an exact admitted . Resident 76 stated he was often lined up in the hallway outside of the dining hall and not allowed to enter. Resident 76 stated, it is what it is, when asked how being lined up in the hallway outside of the dining hall made him feel. Resident 76 stated the facility had never asked him what time he wanted to eat or if he wanted to eat in the dining hall. Resident 76 stated he would like to eat when he is hungry. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 11:52 a.m. with RD 1, RD 1 stated dining group one was independent feeders and when they finished eating the dining hall was cleaned. RD 1 stated after the dining hall was cleaned dining group two were allowed to enter and eat. RD 1 stated dining group two were dependent feeders. RD 1 stated she expected if there were empty tables available in the dining hall Resident 5, Resident 56, and Resident 76 should had been allowed to enter and eat. RD 1 stated Resident 5, Resident 56, and Resident 76 should not have been lined up in the hallway and told not to enter. RD 1 stated it was Resident 5, Resident 56, and Resident 76 right to eat when brought to the dining hall by facility staff. During an interview on 3/22/24 at 10:15 a.m. with the Director of Nursing (DON), the DON stated dependent feeders were fed separately to ensure one to one assistance was available. The DON stated Resident 5, Resident 56, and Resident 76 should not have been lined up in the hallway outside of the dining hall and told not to enter. The DON stated Resident 5, Resident 56, and Resident 76 rights and dignity were violated when they were not allowed to enter and eat at the same time as the independent eaters. During a review of the facility's policy and procedure (P&P) titled, Patients Rights and Responsibilities, dated 5/2023, the P&P indicated, .considerate and respectful care, and to be made comfortable. They have the right to respect .have personal privacy respected. During a review of the facility's job duty description document titled, Certified Nursing Assistant I, dated 9/13/23, the document indicated, .assures that the rights of all patients are respected and maintained by allowing for privacy, confidentiality, and dignity in the provision of service. During a review of the facility's job duty description document titled, Licensed Vocational Nurse I, dated 9/13/23, the document indicated, .assures that the rights of all patients are respected and maintained by allowing for privacy, confidentiality, and dignity in the provision of service.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51345 Based on observation, interview, and record review, the facility failed to ensure comprehensive assessments were conducted for one of nine sampled residents (Resident 64) when Resident 64's Nutritional Risk Assessment was not completed on readmission and quarterly in accordance with Minimum Data Set (MDS- a federally mandated resident assessment tool); and Resident 64's Nutritional Risk Assessments and MDS did not include a direct observation and communication with Resident 64. These failure resulted in Resident 64 not receiving an appropriate diet and put Resident 64 at risk of not having her dietary needs met. Findings: During a concurrent observation, interview, and record review on 3/18/25 at 12:40 p.m. with Resident 64, in Resident 64's room, Resident 64 was lying in bed in upright position eating her lunch meal. Resident 64 was awake, alert and oriented to person, place, time and event. Resident 64 was pointing to her food, and stated, . it is a small portion. Resident 64's meal tray ticket indicated portion size small. Resident 64 stated, I want a regular portion . this is not enough for me. Resident 64 stated she had never see or spoke to a dietitian, and she had informed the kitchen manager about disliking her small food portion. During a record review of Resident 64's Admission Record (AR), dated 3/20/25, the AR indicated, Resident 64 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. During a review of Resident 64's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 1/22/25, the MDS section C indicated, Resident 64 had a (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 64 was cognitively intact. During an interview on 3/18/25 at 4:23 p.m. with Resident 64, in Resident 64's room, Resident 64 stated she did not agree about the small portion. Resident 64 stated, I am okay losing weight .they can cut back on different items in my tray, I want my regular portion of my meal. During a concurrent interview and record review on 3/21/25 at 11:57 a.m. with the Director of Nursing (DON), the DON reviewed Resident 64's current physician's order summary report dated 12/30/24, the Physician's order summary indicated diet no added salt, diet regular texture, thin consistency (a diet consisting of liquids that flow like water). The DON stated Resident 64 should be receiving a regular portion based on the physician's order. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/21/25 at 8:44 a.m. with Registered Dietitian (RD) 1, RD 1 stated she completed, nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports with the assistance of Certified Nursing Assistants (CNA) and Licensed Vocational Nurses (LVN). RD 1 stated, [CNA's and LVN's] are my eyes. RD 1 stated she reviewed CNA and LVN documentation for evidence of weight loss, weight gain, muscle wasting, bony prominence and frailness to complete nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports. RD 1 stated she called the nursing station and asked CNA's or LVN's if there was evidence of weight loss, weight gain, muscle wasting, bony prominence and frailness for each resident to complete nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports. RD 1 stated she relied on CNA's, LVN's, and the DM to complete nutritional assessments because she was not physically onsite and could not physically assess the resident. RD 1 stated, I rely on CNA's and LVN's to do the standard of practice of a focused nutritional assessment. RD 1 stated her nutritional assessment was a chart review and CNA's or LVN's completed the physical assessment. RD 1 stated she was responsible in completing all residents' nutritional assessments. During an interview on 3/21/25 at 2:37 p.m. with Dietary Manager (DM), the DM stated she's been a dietary manager at the facility since 4/2024 and was not certified dietary manager. The DM stated Resident 64's was on small portion, and she was aware of Resident 64's disliking small portion. The DM stated she was not informed of change in diet for Resident 64. The stated. I feel bad, she's been getting small portion. The DM stated Registered Dietitian (RD) 1 and nurses communicates with the kitchen verbally or using the diet change form. The DM stated she cannot recall if diet change form was given to the kitchen. During a telephone interview on 3/21/25 at 2:49 p.m. with RD 1, RD 1 stated she was working full time for the facility, and it is 100 percent remote. RD 1 was not aware of diet change, and stated, . there was a communication dropped here. RD 1 stated she completes all residents' nutritional assessments including MDS. During a review of Nutritional Risk Assessment, Resident 64's Nutritional Risk Assessments were completed on 4/27/23 and 4/26/24. The admission assessment, effective date 4/25/23, electronically signed by RD 1 on 4/27/23, the Nutritional Risk Assessment indicated, Diet order: NAS Regular. The Annual Assessment, effective date 4/19/24, electronically signed by RD 1 on 4/26/24, the Nutritional Risk Assessment indicated, Diet order: NAS (no added salt) Regular, Small Portions. During an interview on 3/22/25 at 11:02 a.m. with the DON, the DON stated RD 1 worked 100 percent remotely and was not physically present to assess facility residents. The DON stated RD 1 should have completed a readmission assessment when Resident 64 returned from acute hospital. The DON stated Resident 64's diet order from readmission was a no salt added regular. The DON stated diet form was given to the kitchen during readmission, and stated, .verified with the admission nurse. The DON stated Resident 64's diet was ordered when resident returned from the acute hospital on 12/27/24. The DON stated RD 1 should do re-admission, quarterly, annual, and significant change assessments. During a review of facility's policy and procedure (P&P) titled, Comprehensive Nursing Assessment/Reassessment, dated 1/2001, the P&P indicated, .All residents will receive comprehensive assessment by licensed nursing staff upon admission, quarterly, upon significant change of condition and upon readmission as part of the interdisciplinary team; Procedure: 2. The nursing admission data will become part of a multidisciplinary assessment and care plan . (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Nutrition Screening, Assessment & Re-assessment, revised date 9/18, the P&P indicated, .Nutrition assessment will be performed by an RD within 48 hours of notification and summary documented in the medical record. Data may be gathered from the medical record, patient/family interview and staff responsible for the care of the resident . During a review of Center for Medicare and Medicaid Services (CMS)'s RAI (Resident Assessment Instrument) Version 3.0 Manual CH 1.3: Completion of RAI, dated 10/2024, the reference indicated, The RAI has multiple regulatory requirements . (3) the assessment process includes direct observation, as well as communication with the resident and direct staff on all shifts .

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47888

Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a detailed approach to care customized to an individual resident's needs) for 2 of 24 sampled residents (Resident 1 and Resident 76) when:

1.The facility did not implement a person-centered care plan for Resident 1, who needed feeding assistance and verbal prompting throughout eating his meal because of blindness.

This failure of implementing an individualized care plan for Resident 1 had the potential to place Resident 1's safety at risk and his specific needs not being met.

2.Resident 76 did not have a care plan for a wound treatment for his deep tissue injury (DTI- a serious type of pressure injury, involves damage to underlying soft tissues, potentially leading to a purple or maroon discoloration of the skin) to the outer left foot.

This failure placed Resident 76 at risk for complications from not having care needs planned by licensed nurses to determine if nursing intervention needed to be added, changed, or completed.

Findings:

1. During a review of Resident 1's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/21/25, the Face Sheet indicated, Resident 1 was admitted to the facility on [DATE].

During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 3/6/25, the MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 11 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was moderately impaired.

During a review of Resident 1's Medical Diagnosis (MD), dated 3/21/25, the MD indicated Resident 1 was diagnosed with legal blindness (severely limited vision), epilepsy (a brain disorder that causes recurring seizures, which are sudden bursts of abnormal electrical activity in the brain that can lead to temporary changes in behavior, sensation, or movement), major depressive disorder (a mental health condition characterized by persistent sadness, loss of interest in activities, and difficulty functioning in daily life) and morbid (severe) obesity (too much body fat).

During a review of Resident 1's Social Services Assessment (SSA), dated 12/4/24, the SSA indicated, . Ancillary needs [additional or supporting services and resources that help a patient function better or achieve their goals] . Vision: specify: Legally blind, able to see little .

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/18/25 at 12:10 p.m., with Resident 1, in the dining room, staff members prompted Resident 1 to where each food item was on his plate and what type of food was in his bowls at the beginning of his meal. The staff members were also serving food trays for other residents so Resident 1 was left alone at times. Resident 1 was putting his spoon in his salad thinking it was soup and putting his fingers into the bowls to be able to distinguish what food was where. Resident 1 stated he could not see what food was on his plate and needed staff members to tell him where food items were, or else I'm just guessing while eating. During a concurrent interview and record review on 3/20/25 at 2:42 p.m., with the Assistant Director of Nursing (ADON), Resident 1's Care Plans were reviewed. The care plan indicated Resident 1 had a care plan for insufficient vision due to being legally blind, but nothing in terms of feeding or monitoring Resident 1 for eating safety because of that blindness. The ADON stated she was responsible for resident care plans, but all nursing staff could implement or modify a care plan. The ADON stated care plans are the foundation of care for all residents. The ADON stated care plans need to be person-centered because all residents have different needs and Resident 1's was not person-centered related to blindness and eating. The ADON stated the facility policy and procedure (P&P) Comprehensive Care Plan was not followed. During a concurrent interview and record review on 3/20/25 at 5:13 p.m., with Licensed Vocational Nurse (LVN) 4, Resident 1's Electronic Medical Record (EMR), dated 3/20/25 was reviewed. The EMR indicated Resident 1 did not have a care plan related too his blindness and eating safely. LVN 4 stated Resident 1 should have had a care plan in place that was dedicated to eating and his blindness. LVN 4 stated Resident 1 should require a staff member to be with him at all times and give him instruction while he eats. LVN 4 stated Resident 1 needs this for his safety, as he could burn himself touching his food with his fingers. LVN 4 stated Resident 1 was legally blind and unable to see. LVN 4 stated person-centered care plans are important so residents are properly taken care of and Resident 1 was not. During an interview on 3/21/25 at 2:20 p.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated she knew Resident 1 well and he was blind. CNA 8 stated the facility told CNA's to get Resident 1 into the dining room for every meal due to safety concerns when he is eating, but that was not in his care plan. CNA 8 stated she was never told to prompt him throughout his meal while eating, but that would be helpful for him. CNA 8 stated a care plan for Resident 1's eating specifically would have been helpful for all staff to get on the same page. CNA 8 stated because the care plan was not person-centered Resident 1 could have been in danger of being burned and it makes his life harder. During an interview on 3/22/25 at 9:52 a.m., with Registered Nurse (RN) 1, RN 1 stated she was the nurse for Resident 1 this past week. RN 1 stated Resident 1 was handicapped in terms of vision. RN 1 stated it was important for staff to know Resident 1 needed constant assistance with eating. RN 1 stated the verbal prompting while eating needed to be constant and staff should never leave his side. RN 1 stated Resident 1 could have gotten burned or injured because of the lack of direction. RN 1 stated he could have grabbed something sharp as well. RN 1 stated staff members did not follow the facilities P&P Comprehensive Care Plan. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Nursing and Rehabilitation Center	275 South Oak Avenue Oakdale, CA 95361

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 3/22/25 at 10:15 a.m., with the Director of Nursing (DON), the DON stated care plans give staff the structure about what to do with the residents. The DON stated care plans are to give residents consistency of care. The DON stated Resident 1's care plan should have been person-centered and had blindness with eating safety care planned together, with interventions for safety. The DON stated because this was not care planned it was a safety issue for Resident 1. The DON stated a potential outcome of this issue could have been weight loss, frustration, and overall negative affect on his health. The DON stated Resident 1 could have easily caused harm to himself. The DON stated staff were not following the P&P Comprehensive Care Plan for Resident 1.

During a review of the facility's P&P titled, Comprehensive Care Plan, dated January 2024, the P&P indicated, .Each resident will have a comprehensive care plan that includes measurable objectives and time frames to meet his/her medical, nursing . needs. Care plans . shall be used in developing daily care needs and routines . PROCEDURE: . The comprehensive care plan has been designed to: a. Incorporate identified or potential problem areas. b. Incorporate risk factors associated with identified or potential problems . Identify the professional services that are responsible for each element of care .

49949

2. During a concurrent interview and record review on 3/20/25 at 5:07 p.m. with License Vocation Nurse (LVN) 1, Resident 76's Treatment Administration Record (TAR- essential for documenting medication administration details) dated 2/22/2025 was reviewed. The TAR indicated, [box] Order Summary: Treatment-outer left foot DTI (DTI- a serious type of pressure injury, involves damage to underlying soft tissues, potentially leading to a purple or maroon discoloration of the skin) -Paint with [brand name of antiseptic] Solution every day and night shift for Pressure Injury . LVN 1 stated there were no care plan for Resident 76's DTI treatment order. LVN 1 stated a care plan should have been develop the same time the treatment order was done. LVN 1 stated a care plan was important to make sure the DTI was acknowledged. LVN 1 stated, the care plan should have had goals and interventions specific to the DTI. LVN 1 stated without the care plan the DTI could have gotten worse or better and we would not know. LVN 1 stated the nurse who did the treatment order was responsible for developing the care plan. LVN 1 stated all the nurses were responsible to ensure the care were updated.

During an interview on 3/21/25 at 11:40 a.m. with the Registered Nurse (RN) 2, RN 2 stated there should be a care plan for the DTI. RN 2 stated, The care plan was our guideline and time bounded [how long the treatment plan should be done] and allow for the nurses to change, update or modify the treatment plan. RN 2 stated the care plan was used to communicate with the Certified Nursing Assistant (CNA). RN 2 stated the care plan allowed the nurses to track the progress of the DTI. RN 2 stated Resident 76's DTI healing process could have been disrupted and gotten worse without the care plan. RN 2 stated the care plan should have been done the same time as the treatment order.

During an interview on 3/21/25 at 12:03 p.m. with the Minimum Date Set Nurse (MDSN), the MDSN stated, there should have been a care plan for the DTI. The MDSN stated, the initial nurse should be the one to do the care plan when they got the new order. The MDSN stated, the care plan was needed to guide the care for the resident. MDSN stated, the care plan tells the staff how to provide care for each specific resident. MDSN stated resident goals and interventions would not be tracked. MDSN stated, the DTI could have worsened without the care plan. MDSN stated Resident 76 could have a bad outcome.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/22/25 at 11:27 a.m. with the Director of Nursing (DON), the DON stated, Anytime there is a new wound there should be a care plan. The DON stated all nurses were responsible for making sure care plans were in place. The DON stated the nurse who did the initial treatment order should have initiated the care plan. The DON stated, a Care plan was a guideline and should have been followed. The DON stated the care plan was personalized for each resident and gave specific guidelines on how to care for them. The DON stated the DTI could have gotten worse without the care plan. During a review of Resident 76's Admission Record (AR-a document with personal identifiable and medical information), dated 3/21/25 indicated Resident 76 had diagnoses of Hemiplegia (partial weakness or a reduced ability to move on one side of the body, often resulting from stroke (a medical emergency that occurs when blood flow to the brain is interrupted or reduced) and hemiparesis (medical condition characterized by weakness or paralysis on one side of the body) following cerebral infraction (stroke), dysphagia (difficulty swallowing), Parkinsonism (a group of neurological conditions characterized by movement disorders, including slow movements, rigidity, and tremors) and constipation. During a review of Resident 34's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 12/12/2024, indicated the Brief Interview for Mental Status (BIMS) score was 5 out of 15 (a BIMS score of 13-15 indicates cognitively intact (having clear thinking, learning, and memory, which allows someone to perform daily tasks.), 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 76 had severe impairment. During a record review of the Resident 76's [Facility Name] Order Audit Report (OAR) dated 3/21/2025, the OAR indicated, Order date: 02/22/2025 Order Summary: Treatment-outer left food DTI-Paint with [brand name antiseptic] Solution every day and night shift for Pressure Injury. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plan dated 1/21, the P&P indicated, Each resident will have a comprehensive care plan that includes measurable objective and time frame to meet his/her medical nursing, mental and psychological needs. Care plan shall incorporate goals and objective which lead to the resident's highest obtainable level of independence and shall be used in developing daily care needs and routines.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51345 Based on observation, interview, and record review, the facility failed to review and revise a care plan (a detailed approach to care customized to an individual resident's needs) to reflect assessment and interventions for one of nine sampled residents (Resident 64) when Resident 64's care plans was not reviewed and revised by the Interdisciplinary team (IDT-group professional and direct care staff that development a plan of care for a resident) after re-admission (12/27/24). This failure resulted in Resident 64 being served the incorrect diet for her meals and had the potential to place Resident 64 at risk for unintended weight loss. Findings: During a concurrent observation and interview on 3/18/25 at 10:48 a.m. with Resident 64, in Resident 64's room, Resident 64 stated she's been at the facility for two and a half years. Resident 64 stated she had a concern about her food and stated, I want you to comeback when my lunch tray is here. During a record review of Resident 64's Admission Record (AR), dated 3/20/25, the AR indicated, Resident 64 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], the MDS section C indicated, Resident 64 had a Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) score of 15, which indicated Resident 64 was cognitively intact. During a concurrent observation, interview, and record review on 3/18/25 at 12:40 p.m. with Resident 64, in Resident 64's room, Resident 64 was lying in bed in upright position eating her lunch meal. Resident 64 was awake, alert and oriented to person, place, time and event. Resident 64 was pointing to her food, and stated, . it is a small portion. Resident 64's meal tray ticket indicated portion size small. Resident 64 stated, I want a regular portion . this is not enough for me. Resident 64 stated she had never see or spoke to a dietitian, and she had informed the kitchen manager about disliking her small food portion. During an interview on 3/18/25 at 4:23 p.m. with Resident 64, in Resident 64's room, Resident 64 stated she did not agree about the small portion. Resident 64 stated, I am okay losing weight .they can cut back on different items in my tray, I want my regular portion of my meal. During a concurrent interview and record review on 3/21/25 at 11:57 a.m. with the Director of Nursing (DON), the DON reviewed Resident 64's current physician's order summary report dated 12/30/24, the Physician's order summary indicated diet no added salt, diet regular texture, thin consistency (a diet consisting of liquids that flow like water). The DON stated Resident 64 should be receiving a regular portion based on the physician's order. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 2:37 p.m. with Dietary Manager (DM), the DM stated she's been a dietary manager at the facility since 4/2024 and was not certified dietary manager. The DM stated Resident 64's was on small portion, and she was aware of Resident 64's disliking small portion. The DM stated she was not informed of change in diet for Resident 64. The stated. I feel bad, she's been getting small portion. The DM stated Registered Dietitian (RD) 1 and nurses communicates with the kitchen verbally or using the diet change form. The DM stated she cannot recall if diet change form was given to the kitchen. During a telephone interview on 3/21/25 at 2:49 p.m. with RD 1, RD 1 stated she was working full time for the facility, and it is 100 percent remote. RD 1 was not aware of diet change, and stated, . there was a communication dropped here. RD 1 stated she completes all residents' nutritional assessments including MDS. During a concurrent interview and record review on 3/21/25 at 3:14 p.m. with MDS Nurse (MDSN), the MDSN stated she is responsible for completing the MDS, updates nursing care plans and facilitates care conferences. The MDSN reviewed Resident 64's Electronic Medical Record (EMR - a digital version of patient's chart), and stated Resident 64's last Interdisciplinary team (IDT) weight meeting was 8/13/24 and care conference was 10/21/24. The MDSN stated IDT review care plan on admission, quarterly, and significant change of condition and revised as needed. The MDSN stated Resident 64's small portion diet was removed when she was readmitted back at the facility on 12/27/24. The MDSN stated, . I think there was a miscommunication about her diet. The MDSN stated dietary is responsible for updating the nutrition care plan. The MDSN stated Resident 64 was alert and oriented and has the right to make decision regarding her care and treatment, and stated, .still need to educate her. During an interview on 3/22/25 at 11:02 a.m. with the DON, the DON stated RD 1 worked 100 percent remotely and was not physically present to assess facility residents. The DON stated Resident 64's diet was ordered when resident returned from the acute hospital on 12/27/24. The DON stated RD 1 should do re-admission, quarterly, annual, and significant change assessments. The DON stated the dietitian was responsible for developing, revising, and updating nutrition care plan for admission, readmission, quarterly, annual and significant change of condition assessments. The DON stated care plan should be updated to deliver the right services for the residents. During a review of Resident 64's electronic medical record (EMR) titled, Care Plan Report, dated 4/27/23 and 11/20/24, the report indicated, .The resident has nutritional problem or potential nutritional problem . Provide and serve diet/texture NAS (no salt added), Regular, Small Portion .RD (Registered Dietitian) to evaluate and make diet change recommendations [as needed]. During a review of facility's policy and procedure (P&P) titled, Comprehensive Care Plan, revised on 1/24, the P&P indicated, . 5. Care plans are reviewed weekly, upon readmission to the facility following an acute hospital stay, when change of condition dictates, and quarterly with IDT care conferences. They are revised/updated as needed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview and record review, the facility failed to meet professional standards of practice for four of 18 sampled residents (Resident 4, Resident 23, Resident 33, and Resident 88) and follow the policy and procedure when: 1. Certified Nursing Assistant (CNA) 5 and CNA 6 did not file and a reported allegation of abuse to [NAME] President or Long Term Care Designee and notify the appropriate agencies for Resident 23. This failure resulted in Resident 23's allegation to go uninvestigated and had the potential for Resident 23's safety concerns to not be met. 2. Registered Nurse (RN) 1 did not follow the physician's order (PO-a written instruction from a healthcare provider, such as a doctor, that outlines specific medical treatments, tests, or procedures for a residents) for Resident 33 when her systolic blood pressure (SBP- the pressure in your arteries when your heart beats and pumps blood throughout your body, measured in millimeters of mercury [mmHg]) was above 160 mmHg (less than 120 mmHg is recommend) and RN 1 did not accurately document Resident 33's blood pressure in the clinical chart. This failure lead to Resident 33 not received prescribed medication for her elevated blood press and Resident 33's physician was not be notified of Resident 33 blood pressure. 3. Resident 4 was not provided assistive eating devices(foam grips on her fork, spoon and knife. Tools designed to help individuals with physical limitations eat more independently, promoting self-care and improving quality of life) per her diet tray card order. This had the potential for Resident 4 to have a decrease in oral intake, independence and cause frustration during meals. 4. Resident 88 had medication in a medicine cup on his bedside table (serves as a surface for food trays and can hold personal items such as phones, laptops, or books) without a self-administration of medications assessment completed, nor nursing staff present. This failure had the potential to put Resident 88's and other facility residents, safety at risk and his specific needs not being met. Findings: 1.During an interview on 3/19/25 at 3:55 p.m. in Resident 23's room Resident 23 stated [Certified Nursing Assistant 6] came to my room to change my brief. Resident 23 stated, I did not poop. I urinated; he stuck his fingers inside my vagina. Resident 23 stated she told Certified Nursing Assistant (cna) 5 about the sexual abuse allegation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/25 at 3:58 p.m. with CNA 5, CNA 5 stated Resident 23 stated CNA 6 stuck his finger in her vagina. CNA 5 stated, the charge nurse told him to not to fill out a form about the allegation. CNA 5 stated the charge nurse told him Resident 23 had a history of making false accusation against staff members and to not filed out a form. CNA 5 stated People from higher up told me this was normal for her. CNA 5 stated, I was re-assured to not do anything. CNA 5 stated he received training on abuse during his orientation. CNA 5 stated he should have filed and the correct form for notification of the incident. CNA 5 stated staff member were mandated reporters (an individual duty to report known or suspected abuse or neglect). CNA 5 stated Resident 23 could have felt stressed, worried and could have lost trust in facility staff if her allegation was not reported. CNA 5 stated it was all staff members responsibility to report allegation of abuse. CNA 5 stated he should have reported it to the Director of Nursing (DON) and proper authorities. During an interview and record review 3/19/25 at 4:08 p.m. with License Vocation Nurse (LVN) 1, LVN 1 stated she was not aware of the sexual abuse allegation. LVN 1 stated, CNA 5 should have filed out paper work and reported to the supervisor and management. LVN stated, We need to make sure the resident felt safe and assured they are taken care of. LVN 1 stated, Resident 23 could have felt depressed and unsafe. During an interview on 3/19/25 at 5:41 p.m. with CNA 6, CNA 6 stated, I remember I was changing her (Resident 23) and she constantly needed to be changed. CNA 6 stated, I was using the wipes to clean her bottom due to bowel movement. CNA stated Resident 23 accused him of inserting three fingers into her rectum during the brief change. CNA 6 stated he notified the nurse on duty that day but was told to not do anything additional. CNA 6 stated reporting abuse allegation was important for resident safety. During an interview on 3/20/25 at 2: 25 p.m. with the Social Services Director (SSD), the SSD stated CNA 5 or CNA 6 should have reported the sexual abuse allegation to management. The SSD stated law enforcement, California Department of Public Health and Ombudsmen should have been notified. The SSD stated it was important to notify the authorities to protect Resident 23's safety. The SSD stated the Resident 23 could have been depressed withdrawn and isolated. The SSD stated Resident 23 could have had behavioral issues and mood swings. The SSD stated all staff were responsibility to report sexual abuse allegations to proper authorities. During an interview on 3/20/25 at 2:56 p.m. with the Director of Staff Development, the DSD stated, CNA 5 and CNA 6 should have reported to local authority such as, ombudsmen, police. The DSD stated, CNA 5 and CNA 6 should have reported the abuse allegation for Resident 23's well-being and safety. The DSD stated CNA 5 and CNA 6 had training abuse when they both were hired. During an interview 3/22/25 at 12:05 p.m. with the Director of Nursing, the DON stated, CNA 5 and CNA 6 should have notified the ADM or DON about the abuse allegation. The DON stated the staff did not follow their policy regarding reporting abuse. During a review of Resident 23 s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/30/25the MDS section C indicated Resident 23 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 23 was cognitively intact. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Abuse Prohibition Review dated 01/21, the P&P indicated, Any employee who suspects an alleged violation shall immediately notify the VP [Vice President] or LTC [Long Term Care] or Designee and notify the appropriate agencies not later than 24 hours During a review of the facility's job description and competency evaluation (JD&CE) titled, Certified Nursing Assistant 1, dated no date the JD&CE indicated, Identified patients at risk for abuse and/or neglect, as well as associated signs and symptoms. Adhere to mandatory reporting requirements for healthcare professional per Administrative Policy and Procedure . 2.During a review of Resident 33's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/21/25, the AR indicated Resident 33 was admitted on [DATE], with diagnoses of diabetes mellitus (DM- a chronic metabolic disorder characterized by high blood sugar (glucose) levels), end stage renal disease (ESRD- condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products from the blood), pain, major depressive disorder, hypertension (high blood pressure) and pain. During a review of Resident 33 s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/1/2025 MDS section C indicated Resident 33 had a Brief Interview for Mental Status(BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 33 was cognitively intact. During a review of Resident's 33's PO, dated 1/22/2025, the PO indicated, [box] Order Summary: [Brand name] tablet 25 mg [milligram-unit of measurement] give 25 mg by mouth every 6 hours as needed for hypertension SBP [systolic blood pressure-the top number in a blood pressure reading, typically expressed in millimeters of mercury (mmHg)] [greater]160 . During an observation at 3/18/25 at 10:36 p.m. in Resident 33's room, Registered Nurse (RN) 1 took Resident 33's blood pressure. RN 1 stated Resident 33's blood pressure reading on the machine was 206/96 mmHg (millimeter/Hg mercury unit of measurement) on the right arm and 186/84 mmHg on the left arm. During an interview on 2/18/25 at 5:46 p.m. with RN 1, RN 1 stated she did not offer [brand name] blood pressure medication per the physicians order. RN 1 stated she should have offered the [brand blood pressure medication] when Resident 33 systolic blood pressure was 206 and 185. RN 1 stated Resident 33 could have a stroke or heart attack because of elevated blood pressure and there could have been additional consequences to her heart. During an interview on 3/22/25 at 11:44 a.m. with the DON, the DON stated the physicians order (PO) should have been followed. The DON stated RN 1 should have followed the PO when the systolic blood pressure was above 160. The DON stated Resident 33 could have complication such as a stroke and heart attack from not having her blood pressure controlled. The DON stated RN did follow professional standard of practice when she did not offer the medication for resident 33's when the systolic blood pressure was above 160. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Medication are administration General Guidelines dated 01/25, the P&P indicated, Medication Administration: 1. Medication are administered in accordance with written orders of the prescriber . 51059 3. During a review of Resident 4's Admission Record (AR- document containing resident personal information), dated 3/20/25, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnosis which included hemiplegia (muscle weakness) affecting right dominant side, seizures (sudden burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness.), pain in right wrist, osteoarthritis (chronic joint disease and breakdown of cartilage) and dementia (decline in mental abilities, including memory, thinking, and reasoning). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 2/5/25, the MDS Resident 4's diet tray card stated, .devices .foam grips on silverware . The DM stated Resident 4's silverware did not have foam grips on the fork, spoon, or knife and her diet tray card order was not followed. The DM stated foam grips were round, soft tubes placed over silverware to provide assessment indicated Resident 4's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 00 out of 15 which indicated Resident 4 had severe cognitive impairment (a decline in thinking abilities, like memory, reasoning, and problem-solving). The MDS assessment indicated Resident 4's functional abilities (the capacity to perform daily tasks and activities) had no impairments on her upper extremities. During a concurrent observation and interview on 3/19/25 at 11:54 a.m. with the Dietary Manager (DM), in the kitchen during tray line, Resident 4's lunch tray was observed in the tray cart with no assistive eating devices. a comfortable and secure grip when handling silverware. The DM stated Resident 4 required foam grips on silverware to hold her utensils and feed herself. The DM stated all kitchen staff were responsible to ensure trays were plated per the diet tray card order During an interview on 3/19/25 at 2:55 p.m. with Registered Dietician (RD) 2, RD 2 stated she expected all trays to be plated per the diet tray card order. RD 2 stated diet tray cards were an order and were expected to be followed. RD 2 stated it was important Resident 4 received foam grips on her silverware to promote independence when eating. RD 2 stated Resident 4 was at risk for decreased oral intake if she could not hold her silverware to eat. During an interview on 3/20/25 at 11:52 a.m. with RD 1, RD 1 stated foam grips on silverware was an assistive eating device. RD 1 stated all assistive eating devices were listed on the diet tray card order and were expected to be followed. RD 1 stated she expected all kitchen staff to plate trays accurately per the diet tray card order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/25 at 4:51 p.m. with CNA7, CNA 7 stated he was familiar with Resident 4. CNA 7 stated Resident 4 required assistive foam grips on her silverware to feed herself independently. CNA 7 stated Resident 4's assistive eating devices were listed on the diet tray card order. CNA 7 stated kitchen staff were responsible to plate all trays per the diet tray card order. CNA 7 stated it was important Resident 4 received her assistive foam grip silverware to promote independence when eating. CNA 7 stated Resident 4 was at risk for decreased oral intake if she could not hold her silverware. During an interview on 3/20/25 at 5:13 p.m. with LVN 5, LVN 5 stated kitchen staff were responsible to plate all trays per the diet tray card order and ensure assistive eating devices were present on the tray. LVN 5 stated diet tray cards were an order and were expected to be followed. LVN 5 stated Resident 4 had not received her silverware foam grips and was at risk for decreased oral intake and decreased independence. During a concurrent interview and record review on 3/22/25 at 10:15 a.m. with the Director of Nursing (DON), a picture of Resident 4's diet tray card order, dated 3/19/25, was reviewed. The facility's policy and procedure (P&P) titled, Adaptive Self Feeding Devices and Diet Tray Cards, dated 1/2021, was reviewed. The DON stated Resident 4's diet tray card stated, .devices .foam grips on silverware . The DON stated all assistive eating devices were placed on the meal ticket as an order to follow. The DON stated per facility policy kitchen staff were responsible to plate Resident 4's assistive eating silverware on the meal tray per the diet tray card order. The DON stated facility P&P was not followed by kitchen staff. The DON stated she expected all diet tray card orders to be followed. The DON stated Resident 4 was at risk for decreased oral intake if she could not hold her silverware to eat. The DON stated Resident 4 enjoyed eating her meals independently and was at risk for decreased independence and frustration if she could not feed herself. During a review of Resident 4's Diet Order (DO), dated 6/10/24, the DO indicated, Resident 4 had an order for, .foam grips . on silverware. During a review of the facility's P&P titled, Diet Tray Cards, dated 1/2021, the P&P indicated, .each resident shall have a diet tray card .the diet tray card must identify .Resident's diet exactly ordered by the physician . Resident's dining abilities . During a review of the facility's P&P titled, Adaptive Self Feeding Devices, dated 1/2021, the P&P indicated, . The Nutritional Services Department will be responsible for sanitizing the utensil safter each use and plating the devices on the resident's tray . During a review of the facility's P&P titled, Tray Assembly, dated 5/2019, the P&P indicated, .A person designated by the Food and nutrition Services Manager is responsible for seeing that all tray assembled meet therapeutic requirements of the diets, constancy, and personal preferences noted on the tray card . During a review of the facility's job description document titled, Nutrition and Food Service Aide, dated 6/1/24, the document indicated, .assembles, prepares and correctly serves items on patient tray line .sets trays with necessary items .set trays completely . 47888 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 88's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/21/25, the Face Sheet indicated, Resident 88 was admitted to the facility on [DATE]. During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/28/25, the MDS assessment indicated Resident 88's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 88 was cognitively intact. During a review of Resident 88's Medical Diagnosis (MD), dated 3/21/25, the MD indicated Resident 88 was diagnosed with sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), cellulitis (a bacterial infection of the skin and the tissues just beneath it) of the right lower leg, chronic kidney disease (damage and loss of function in the kidneys), anxiety (a feeling of worry, nervousness, or fear, often about things that might happen, and it can involve physical symptoms like a racing heart or sweating) and gastroesophageal reflux disease (GERD- a condition where stomach acid and contents back up into the esophagus (food pipe), causing heartburn and other symptoms). During a concurrent observation and interview on 3/18/25 at 1:05 p.m., with Resident 88, in Resident 88's room, Resident 88 was by himself and there were two white round pills (medications) sitting on his bedside table while he was lying in bed. Resident 88 stated the medications had been there awhile and he did not know what they were. During a concurrent observation and interview on 3/18/25 at 1:15 p.m., in Resident 88's room, Registered Nurse (RN) 1 walked in the room and saw the two white round pills sitting in the medication cup on the bedside table. RN 1 stated she left the pills on his bedside table because he took over fifteen minutes and she didn't have time to wait for him to take them, so she left. RN 1 stated the two pills were simethicone (treats the symptoms of gas, such as fullness, pressure, and bloating) and he takes them daily for his GERD. During an interview on 3/20/25 at 2:42 p.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 88 should not have had medications sitting at the bedside without nursing staff present. The ADON stated Resident 88 needed to pass an assessment done by staff in order to self-administer medications and staff had never done one. The ADON stated he also needed a physicians order to self-administer medications and he did not have that either. The ADON stated this was a safety issue for Resident 88 due to the lack of assessment and no physicians order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/22/25 at 9:38 a.m., with RN 1, RN 1 stated she was the nurse for Resident 88 when the medications were observed on the bedside table without staff present. RN 1 stated the medications should not have been left for Resident 88 to take on his own. RN 1 stated the expectation would be for her to watch Resident 88 take the medications. RN 1 stated because she left the pills at his bedside, any resident could have come in his room and took them without any staff knowing. RN 1 stated Resident 88 could have not taken the medication at all, or the medication dropped on the ground and staff would never have known. RN 1 stated Resident 88 usually takes his medication as ordered, but that day he didn't. During an interview on 3/22/25 at 10:15 a.m., with the Director of Nursing (DON), the DON stated Resident 88 would need to qualify to be able to self-administer medications and he did not. The DON stated some issues with the nurse leaving the medication for him to take were Resident 88 might not know the importance of taking the medication on time and he might not take the medication and staff wouldn't know. The DON stated this could have caused a medication error and it was a safety risk for Resident 88. The DON stated a confused resident could have come by and took the medications without staff knowing as well. The DON stated the self-administration medication was not completed for Resident 88 and the facility policy and procedure (P&P) Medication Administration was not followed. During a review of the facility's Self-Administration Assessment (SAA), not dated, the SAA indicated, . Instructions: before performing this assessment, verify that there is a physician order in the residence chart for self-administration of the specific medication under consideration and that the resident has signed the appropriate documents stating the desire to self-administer his own medication . Assessment Criteria: . Can correctly state name of medication and what it is used for . During a review of the facility's P&P titled, Medication Administration, dated January 2025, the P&P indicated, .Medications are administered as prescribed in accordance with . good nursing principles and practices and only by persons legally authorized to do so . Medication Administration: . medications are administered in accordance with written orders of the prescriber . residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care centers interdisciplinary team [IDT] and in accordance with procedures for self-administration of medications and state regulations . the resident is always observed after administration to ensure that the dose was completely ingested .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation interview and record review the facility failed to ensure one of six sampled resident (Resident 42) grooming was maintained when red patches of dried flaky skin were on top of his scalp and on the front of his shirt and pant. This failure resulted in Resident 42 having dried flaky skin on his skirt and pants which made him feel upset and embarrassed and had this had the potential to cause skin infection. Findings: During a concurrent observation and interview on 3/18/25 at 4:50 p.m. in Resident 42's room Resident 42 had patches of dry, white flakes and redness on his head. Resident 42 had the same dry white flakes on the front of his shirt and pants. Resident 42 stated he had a surgical wound treatment to the abdomen and had been not had shower because he did not want his dressing to get wet. Resident 42 gave permission for a photo of his head to be taken. Resident 42 stated he felt bad, uncomfortable and embarrassed of his head. During a concurrent observation and interview on 3/18/25 at 5:07 p.m. with Certified Nursing Assist (CNA) 1, CNA 1 stated she was assigned to Resident 42. CNA 1 stated she was assigned to Resident 42 two times a week. CNA 1 stated, When I first started, I gave him showers twice a week. CNA 1 stated Resident 42 has been refusing showers due to his surgical incision. CNA 1 stated the white flakes on the top of Resident 42's head looked like dried skin and was not normal for him. CNA 1 stated CNAs should have washed his head during showers or bed bath. CNA 1 stated Resident 42's head should have been brush and lotion should have been applied to prevent the dryness. CNA 1 stated, the dried skin could have caused skin irritation and caused the skin to open. CNA 1 stated the open skin could have caused an infection. CNA 1 stated she should have notified the charge nurse (nurse responsible for care). CNA 1 stated Resident 42 could have felt uncomfortable. CNA 1 stated she agreed when Resident 42 stated he felt embarrassed and ashamed of his appearance. CNA 1 stated CNAs were responsible and should had made sure Resident 42's grooming needs were done daily. During an interview and record review on 3/20/25 at 4:39 p.m., with License Vocation Nurse (LVN) 1, LVN 1 stated Resident 42 returned to the long-term care on 3/11/25. LVN 1 stated, Since he has been back, he has a bed bath .does not want his dressing to be wet. LVN 1 stated CNAs should have applied lotion to Resident 42's head after washing it. LVN 1 stated it was important to keep the skin from being dry and flakey to prevent the skin from opening. LVN 1 stated open skin could lead to an infection. LVN 1 stated. Resident 42 could have felt uncomfortable and embarrassed. During an interview on 3/22/25 at 9:15 a.m., with the Director of Staff Development (DSD) 1, DSD 1 stated CNAs were responsible to check on Resident 42's personal grooming and to check his skin daily. The DSD stated the CNA should have documented that Resident 42 was refusing showers, and notified the charge nurses. The DSD stated skin assessment were completed during showers. DSD 1 stated the CNA should have reported the dried skin to the nurses. DSD 1 stated, I trained the CNAs about documenting the skin at all showers and bathing. The DSD stated the dried skin on Resident 42's head should have been treated. The DSD stated, dried skin had the potential to cause an infection. DSD 1 stated Resident 42 could have felt undignified, embarrassed and uncomfortable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/22/25 at 11:57 a.m. with the Director of Nursing (DON) the DON was shown a photo of Resident 42's head. The DON stated, It should not look like that. The DON stated Resident 42's skin was a risk for an infection because it was so dry. The DON stated CNAs were responsible for caring for residents who could not care for themselves. The DON stated each resident should be treated appropriately and their grooming needs should be met. The DON stated residents had right to feel comfortable. The DON stated the dried skin on Resident 42's head was a dignity issue. The DON stated Resident 42 could have felt undignified and uncomfortable. The DON stated Resident 42 could have been depressed and upset with his dry skin. During a review of Resident 48's Admission Record, (AR) dated 3/21/25, the AR indicated Resident 42 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of rectosigmoid junction (type of cancer that originates in the junction between the rectum and sigmoid colon(two parts of the large intestine), diabetes Mellitus (DM- chronic metabolic disorder characterized by high blood sugar levels), muscle weakness, unsteadiness on feet, need assistance with personal care. During a review of Residents 42's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [thought process] and physical function) assessment, dated 3/20/25, the MDS indicated Resident 42's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement on a scale of 1-15 with 15 being the highest score) was 15. Resident 42's cognition was assessed as cognitively intact. During a record review of the facility's policy and procedure (P&P) titled, Residents' Right and Responsibilities dated 8/03/2017, the P&P indicated, Patients have the right to: 1. Considerate and respectful care and to be made comfortable . During a review of the facility's policy and procedure (P&P) titled, Resident Grooming dated 01/24, the P&P indicated, To provide daily grooming and grooming as an activity that meets standards for the health and safety of resident and staff by providing and environment which reduces opportunity for injury and infection .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51345 Based on observation, interview, and record review, the facility failed to assure nursing staff possess the competencies and skill sets necessary to provide restorative nursing services for one of nine sampled residents(Resident 81) when Resident 81 received a restorative nursing service from Certified Nursing Assistant not a certified Restorative Nurse Assistant (RNA-a healthcare worker that assists with rehabilitative care to individuals recovering from illnesses or injuries). This failure had the potential to place Resident 81 at risk for further injury during restorative services. Findings: Based on concurrent observation and interview on 3/18/25 at 9:39 a.m. with Resident 81, in Resident 81's room, Resident 81 was lying in bed, awake, alert and oriented to person, place, time, and event. Resident 81 had a slurred speech during conversation. Resident 81 stated he was getting exercises and walking with the therapist (Certified Nursing Assistant 2). During a record review of Resident 81's Admission Record (AR), dated 3/22/25, the AR indicated, Resident 81 was admitted to the facility on [DATE]. During a review of Resident 81's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/28/25, the MDS section C indicated, Resident 81 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 81 was cognitively intact. During an interview on 3/20/25 2:12 p.m. with Certified Nurse Assistant (CNA) 2/Restorative Nurse Assistant (RNA), CNA 2 stated she's been working as RNA at the facility for two months and worked as CNA when needed. CNA 2 stated there were three other RNAs working at the facility. CNA 2 stated she received orientation with other fell ow RNAs and stated, . but I am not RNA certified. CNA 2 stated she performs and delivers RNA programs to the residents without supervision from other RNAs. CNA 2 stated RNA programs include range of motion (ROM), and ambulation. CNA 2 stated we received referrals from Physical Therapy (PT) when resident is transition to RNA programs. CNA 2 stated RNA programs meeting held monthly with the director of nursing (DON). During an interview on 3/20/25 at 2:34 p.m. with Director of Staff Development (DSD) 2, DSD 2 stated CNA 2 worked as a CNA and RNA at the facility. DSD 2 stated CNA2 was primarily worked as RNA and worked as CNA when needed. DSD 2 stated RNA competency training was not provided by the facility, and unaware that RNAs needed certification. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/21/25 at 3:06 p.m. with RNA 1, RNA 1 stated she's been an RNA at the facility for 2 years. RNA 1 stated she was a certified RNA. RNA 1 stated CNA must be RNA certified to be an RNA. RNA 1 reviewed facility's record titled, Restorative Nursing Assignment, dated 3/21/25, the record indicated CNA 2 was assigned to provide RNA services to twelve residents including Resident 81. RNA 1 reviewed electronic medical record (EMR -a digital version of patient's chart), dated 3/21/25 at 9:20 a.m., the EMR indicated Resident 81 walked for 15 minutes. RNA 1stated EMR indicated CNA 2 documented RNA services for six of 12 residents including Resident 81 were completed. RNA 1 stated CNA 2 was scheduled on 3/21/25 as the morning RNA and another RNA was scheduled for the afternoon. During an interview on 3/21/25 at 5:58 p.m. with RNA 1, RNA 1 stated more training are required to become a certified RNA. RNA 1 stated they do not have RNA competency checklist. RNA 1 stated the DON oversees the RNA programs. During an interview on 3/21/25 at 5:58 p.m. with the director of nursing, the DON stated the facility never had a monthly RNA program meeting, and stated, . that is the plan . didn't happen yet. The DON stated she spoke with CNA 2 and validated CNA 2 has been working as RNA. The DON stated CNA 2 should be RNA certified before working as RNA. The DON stated RNA requires training from professional people to deliver restorative nursing services safely. During an observation and interview on 3/22/25 at 12:00 p.m. with Resident 81, at the hallway, Resident 81 was propelling her wheelchair, well groomed and clean. Resident 81 stated CNA 2 walked him yesterday and stated, . she's been walking me. During a review of facility's Job Description and Competency Evaluation for Restorative Nursing Assistant (RNA), unknown date, the document indicated, . Position Summary: Performs various patient/resident care activities and related non-professional services necessary in caring for the personal needs and comfort of patients/residents; assists in maintenance of a safe, clean environment .Position Qualifications: RNA certificate required.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51345 Based on observation, interview, and record review, the facility failed to ensure medications were securely stored when: 1.Registered Nurse (RN) 3, Licensed Vocational Nurse (LVN) 2, LVN 4, and RN 2 left the facility's medication cart unlocked when they walked away from during medication pass. This failure had the potential to place facility at risk for unauthorized access to medication cart and possible drug diversion. 2.Expired over the counter (OTC) medications were stored in medication cart and medication storage room; and eye drops was stored in medication cart beyond use date. This failure had the potential for residents to received expired medications that were no longer effective. 3.Discontinued oral medications, eye drops, inhalation, and injectables medications were stored in drawers of medication storage room. This failure had the potential to result in facility staff using expired medication and a risk a drug diversion. 4.The facility medication storage room temperature was not monitored to ensure medications were kept within acceptable room temperature and in accordance with manufacturer's instructions. This failure had the potential for residents to received medications that were no longer effective. 1. During a concurrent observation and interview on 3/19/25 at 8:26 a.m. with Registered Nurse (RN) 3, in Hallway 1, RN 3 left the medication unlocked and unattended. RN 3 walked away from the medication cart to the nursing station. RN 3 stated she checked Certified Nurse Assistant (CNA) assignment for Resident 13. During a concurrent observation on 3/19/25 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 2, in Hallway 4, LVN 2 left the medication cart unlocked and walked towards the nursing station. Hallway 4's medication cart was facing the hallway with staff member passing by. During a concurrent observation and interview on 3/20/25 at 8:53 with Licensed Vocational Nurse (LVN) 4, in Hallway 1, Hallway 1 medication cart was unlocked and unattended. Hallway 1's medication cart was facing the hallway with staff member passing by. LVN 4 stated, . I was in the resident room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 3/20/25 at 9:10 a.m. with Registered Nurse (RN) 2, in Hallway 4, RN 2 left the medication cart unlocked and unattended. RN 2 stated she received training about keeping the medication cart locked when away from the medication cart to prevent a resident and staff to access the medications. RN 2 stated there is a potential risk of harming the resident and staff when taking medications without doctor's order. During an interview on 3/20/25 at 4:39 p.m. with RN 3, RN 3 stated medication cart should be kept locked when nurses are away from the medication cart. RN 3 stated unlocked medication cart can give easy access for residents and staff to get medications. RN 3 stated, . can cause drug overdose and drug interaction. During an interview on 3/21/25 at 11:57 a.m. with Director of Nursing (DON), the DON stated her expectation for the nurses is to follow the P&P for medication administration. The DON stated medication cart unlocked and unattended is a safety risk for the residents and staff, and stated, .they can take medications accidentally, it can cause med error and negative consequences for resident and staff. The DON stated nurses must keep the medication cart locked when away from the medication cart. The DON stated it is important to follow the P&P for medication administration to prevent harm to the resident. During a review of facility's Policy and Procedure (P&P) titled, Medication Administration General Guidelines, dated 1/25, the P&P indicated, .Medication Administration:17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse . 2.During a concurrent observation and interview on 3/19/25 at 10:17 a.m. with LVN 2, in Hallway 4's medication cart, LVN 2 stated a bottle of ibuprofen (medication used to relieve pain) 200 milligrams was stored on the top drawer of the medication and the medication's expiration date was 11/24. LVN 2 stated the medication was expired. LVN 2 stated expired medication can be less effective. During a concurrent observation and interview on 3/19/25 at 10:22 a.m. with LVN 2, in medication storage room, LVN 2 stated a bottle of ibuprofen 200 milligrams was stored in the cabinet of the medication storage room and stated the medication's expiration date was 11/24. LVN 2 stated, . it was expired. LVN 2 placed the expired bottle of ibuprofen in a white container, and stated, . for destruction. During a concurrent observation and interview on 3/21/25 at 9:23 a.m. with RN 3, in Transitional Care Unit (TCU) medication storage room, RN 3 stated a bottle of eye drops was stored in the TCU medication cart with open date of 1/26/25 and stated, the medication was .already expired, . only good for 30 days when opened. RN 3 stated the eyedrops was no longer effective and should be thrown away. During an interview on 3/22/25 at 11:02 a.m. with the DON, the DON stated, expired medications should be destroyed and stated, . expired meds are less effective. The DON stated eyedrops should be destroyed beyond 30 days from the opened date. During a review of facility's policy and procedure (P&P) titled, Medication Storage, dated 1/25, the P&P indicated, . 14. Outdated, Contaminated, . are immediately removed from stock, disposed of according to procedures for medication disposal . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/22/2025
NAME OF PROVIDER OR SUPPLIER Oakdale Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 275 South Oak Avenue Oakdale, CA 95361	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3.During an observation and interview on 3/19/25 at 10:22 a.m. with LVN 2, in medication storage room, two bags of sodium cloride (with pharmacy label) were on top of the counter. LVN 2 stated two bags of sodium chloride requires destruction and stated, .the resident already expired. During an observation and interview on 3/20/25 at 10:09 a.m. with RN 2, in the nursing station, RN 2 discarded an open bottle of sodium chloride irrigation solution [475 millimeter] in the black trash can located at the nursing station. RN 2 stated the bottle of sodium chloride can be thrown in a regular trash can and stated, . there was no resident information in the bottle. RN 2 stated sodium chloride is considered a medication. During a concurrent observation and interview on 3/22/25 at 11:02 a.m. with the DON, in the medication storage room, there were four drawers, one drawer labeled discontinued medication, the drawer contained discontinued medications including oral medications, eye drops, inhalation, and injectables. The DON stated all discontinued medications were placed and stored in the drawers of the medication storage room. The DON stated she will review the P&P for medication disposal. During a review of facility's policy and procedure (P&P) titled, Medication Storage, dated 1/25, the P&P indicated, . 14. Outdated, contaminated, discontinued, . are immediately removed from stock, disposed of according to procedures for medication disposal . During a review of facility's policy and procedure (P&P) titled, Disposal of Medications, dated 1/24, the P&P indicated, Policy 1. Discontinued medications . which do not qualify for return to pharmacy, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition; .Procedure 1. The DON and the consultant pharmacist will monitor for compliance with federal and state laws and regulations regarding the disposal of medications. a. The nursing care center should maintain approved containers to separate and securely store different types of pharmaceutical waste until it is scheduled for pick up. B. Authorized personnel who have access to medications should deposit pharmaceutical waste in the appropriately labeled container. Each container used to collect, separate and store each type of pharmaceutical waste will be labeled with the type of waste to be stored in the container. 4. During a concurrent observation and interview on 3/20/25 at 10:38 a.m. with RN 2, in the medication storage room, RN 2 stated there were no temperature monitoring log for medication storage room. RN 2 stated nurses were monitoring the temperature of the medication refrigerator and not the room temperature of the medication room. RN 2 stated nurses were not instructed to check the temperature of the medication room, RN 2 stated the medication room temperature should be check because there are different medications stored in the medication room. RN 2 stated it can affect medications' efficacy when the temperature is high. During a concurrent observation and interview on 3/21/25 at 9:23 a.m. with RN 3, in the medication storage room, RN 3 stated nurses were not instructed to check the temperature of the medication storage room. RN 3 stated the thermometer hanging at the wall inside the storage medication room was not working and stated, . never been working. During an interview on 3/22/25 at 11:02 a.m. with the DON, the DON stated, the medication storage room temperature should be checked and monitored to ensure all the medications were stored following the medications' manufacturer's instructions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's policy and procedure (P&P) titled, Medication Storage, the P&P indicated, . Medications requiring storage at room temperature are kept at temperature ranging from 15C (59F) to 25C(77F) .

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F 0801

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.

51059

Based on interview, and record review, the facility failed to ensure dietetic staff had the appropriate skill sets to carry out the functions of food and nutrition services when:

1. The full-time Dietary Manger (DM) did not have the appropriate qualifications to meet the state requirements of the Health and Safety Code 1265.4 when Registered Dietitian (RD) 2 was only working onsite at the facility one day per week: and

2. RD 1 did not follow current standards of practice for nutrition-focused physical exams when she was a full-time consultant who worked remotely in another state and completed nutrition assessments for the facility.

These failures resulted in the lack of a full-time qualified DM and RD which led to dietetic staff not having adequate supervision, training, and knowledge to carry out food and nutrition services in a safe and sanitary manner which placed 91 out of 91 resident's dining at the facility at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) and/or decreased nutrient intake, both of which had the potential to result in death and/or nutritional related medical complications. The failure of the remote RD not following current standards of practice had the potential to result in resident's not being accurately assessed with a nutrition diagnosis of malnutrition or at risk for malnutrition. Early nutrition intervention of a patient with malnutrition has the potential to decrease length of stay, falls, pressure ulcers, infections, complications, re-admissions and overall health care costs.

Findings:

1. During a review of the State Statue (law), titled Health, and Safety Code - HSC S 1265.4: A licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. Subdivision (b) includes seven pathways to be qualified. One of the pathways: (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.

During a review of the State requirements titled, Title 22 California Code of Regulations (CCR) section S72333 Dietetic Service -General, indicated Dietetic service means a service organized, staffed and equipped to assure that food service to patients is safe, appetizing and provides for their nutritional needs.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/18/25 at 9:26 a.m. with the DM during the initial kitchen tour, the DM introduced herself as the Dietary Manager, also known as the kitchen supervisor. The DM stated she graduated on 1/24/25 from The University of North Dakota with her Nutrition and Foodservice Professional Training Program certification. The DM stated she had not registered or taken the CDM credentialing exam yet. The DM stated she was not qualified to be kitchen supervisor independently until she had her CDM credential. The DM stated she was working under RD 2 until she obtained her CDM credential. The DM stated RD 2 was her preceptor and responsible to provide oversight and training. The DM stated she had been the acting kitchen supervisor since approximately 4/2024 after the previous DM left. The DM stated RD 2 was full-time at the facility from 2022 to 11/2024. The DM stated RD 2 went per diem (a shift requiring to be onsite one day a week) in 11/ 2024 and was only at the facility once a week on Tuesday's. The DM stated RD 1 was a full-time consultant and worked remotely from another state. The DM stated RD 1 did not provide any physical oversight as she was remote. The DM stated there was no RD on site with her Monday, Wednesday, Thursday, Friday, Saturday, or Sunday. The DM stated RD 1 and RD 2 were available by phone call, text, or email if she had questions. The DM stated she had not received formal training on how to perform her job duties as the DM. During an interview on 3/19/25 at 2:55 p.m. with RD 2, RD 2 stated she was full-time at the facility from 6/2022-11/2024. RD 2 stated she went per diem in 11/2024 and was at the facility once a week, on Tuesday's. RD 2 stated the DM had performed kitchen supervisor duties from 11/24/24 to 3/19/25 with no RD on site Monday's, Wednesday's, Thursday's, Friday's, Saturday's, or Sunday's. RD 2 stated the DM had worked since April 2024 to acquire her CDM certification and had just graduated from The University of North Dakota. RD 2 stated the DM was not qualified to be the DM as she had not taken her CDM credentialing exam yet. RD 2 stated she was the DM's preceptor. RD 2 stated the DM needed a preceptor as she was not qualified to be kitchen supervisor until she passed her CDM credential exam. RD 2 stated RD 1 worked full-time remotely in another state and was not physically at the facility. RD 2 stated RD 1 could not provide direct oversight over the DM as she worked remotely in another state. RD 2 stated RD 1 completed nutrition focused physical examinations (a systematic, head-to-toe approach used by Registered Dietitian Nutritionists (RDs) to evaluate a patient's nutritional status, looking for signs of nutrient deficiencies, malnutrition, and other related issues), annual and quarterly nutrition reports, monthly weight variance meetings. RD 2 stated she could not perform oversight over the DM on Monday's, Wednesday's, Thursday's, Fridays, Saturday's, or Sunday's and ensure the DM completed tasks as required. RD 2 stated RD 1 was the acting Manager of Nutrition and Food Services as she was full-time. RD 2 stated as the Manager of Nutrition and Food Services RD 1 was responsible to oversee kitchen responsibilities. RD 2 stated there was a potential the DM made a mistake without a qualified Manager of Nutrition and Food Services on site overseeing her. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/20/25 at 11:52 a.m. with RD 1, RD 1 stated she had been a remote full-time dietitian for the facility for approximately 3 years. RD 1 stated she was available Monday through Friday 8 a.m. to 5 p. m. for the facility via phone call, text, and email. RD 1 stated she did not perform her job duties on site. RD 1 stated she visited the facility once a year for approximately 2-5 days. RD 1 stated approximately 4/2024 was the last time she was onsite at the facility. RD 1 stated she performed a kitchen audit each year when onsite. RD 1 could not state the date of the last kitchen audit she performed. RD 1 stated as the current full-time RD employed by the facility, she was the acting Manager of Nutrition and Food Services. RD 1 stated her job duties included, but were not limited to, nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports, monthly weight variance meetings, updating care plans, communicating with resident's, their families and the provider to recommend supplements or diet changes. RD 1 could not state what RD 2 responsibilities and tasks were as the RD on site. RD 1 stated RD 2 was responsible to oversee all food and nutrition facility policies. RD 1 stated she .assumed . RD 1 completed all job duty tasks that required being on site at the facility such as kitchen audits and overseeing the DM. RD 1 stated the DM had no direct oversight on Monday's, Wednesday's, Thursday's, Fridays, Saturday's, or Sunday's. During an interview on 3/20/25 at 6:05 p.m. with RD 2, RD 2 stated she completed kitchen audits every Tuesday when on site. RD 2 stated she did not share kitchen audit results with RD 1. RD 2 stated she updated all food and nutrition facility policies before she went per diem in 11/2024 and was not responsible to update policies anymore as she was per diem. RD 2 stated RD 1 was responsible to update all facility food and nutrition polices as the acting Manager of Nutrition and Food Services. RD 2 stated she did not routinely perform or compete nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports, monthly weight variance meetings, updating care plans, communicating with resident's, their families and the provider to recommend supplements or diet changes. During an interview on 3/21/25 at 10:43 a.m. with the DM, the DM stated she registered for her CDM credentialing exam on 3/19/25. The DM stated she did not have an exam date yet. The DM stated it would take approximately 7-14 days to receive an exam date. During an interview on 3/22/25 at 10:15 a.m. with the Director of Nursing (DON), the DON stated the DM was the Supervisor Nutrition and Food Services. The DON stated RD 1 was the Manger Nutrition and Food Services. The DON stated RD 1 worked full-time remotely in another state. The DON stated RD 2 was only onsite on Tuesday's. The DON stated the DM was unqualified to be the DM without Manger Nutrition and Food Services direct oversight. The DON stated the DM had not received official training to be the DM. The DON stated without direct oversight from the Manger Nutrition and Food Services the DM had no direct oversight on Monday, Wednesday, Thursday, Friday. Saturday or Sunday. The DON stated the DM was at risk for making an error or not knowing how to perform her job duties with no official training or oversight. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 3/22/25 at 11:51 a.m. with the Administrator (ADM), the facility's Human Recourses (HR) document titled, Oak Valley Hospital District (OVHD) Open Positions, dated 1/3/25, 1/10/25, 1/17/25, 1/24/25, 2/7/25, 2/14/25, 2/21/25, 2/28/25, 12/6/24, 12/13/24, 12/20/24, 12/27/24, 11/27/24, 11/22/24, 11/15/25, 11/8/24, 11/1/24, and 10/25/24 was reviewed. The facility's job duty description titled, Manager Nutrition and Food Services,, dated 10/5/23 was reviewed. The ADM stated there was no job recruitment posting for Supervisor Nutrition and Food Services on the HR document. The ADM stated the DM was the acting Supervisor Nutrition and Food Services. The ADM stated the DM had not taken her CDM credentialing exam and was not qualified to be the full-time DM with no full-time RD oversight. The ADM stated RD 2 was pier diem and only onsite Tuesday's. The ADM stated the DM had no oversight on Monday, Wednesday, Thursday, Friday, Saturday, or Sunday. The ADM stated RD 1 was not the Manager Nutrition and Food Services. The ADM stated there was a job recruitment posting for Manager Nutrition and Food Services. The ADM stated until the Manager Nutrition and Food Services position was filled, he was the acting Manager Nutrition and Food Services. The ADM stated he expected all job duty statements to be adhered to and implemented. During a review of the facility's job description for RD 2, titled, Manager Nutrition and Food Services, dated 10/5/23, indicated, .responsible for the operation and management of Nutrition and Food Services .develops and implements related policies and procedures .general accountabilities .the following are essential job functions and accountabilities .demonstrates knowledge of and adheres to, all applicable professional regulatory practice acts, state/federal regulations and policies and procedures of OVHD, including JCAHO, Title XXII and requirements of other regulatory agencies .maintains professional standards .position qualifications .active registered Dietitian (R.D.) status . During a review of the facility's job description for DM, titled, Supervisor Nutrition and Food Services, dated 3/12/08, the document indicated, .supervises Nutrition and Food Services Staff concerned with the planning, preparation and service of food to residents, staff and guests. Orders or oversees the ordering of food and supplies. Maintains continual awareness of resident needs for optimal nutritional care .maintains current professional licenses and/or certifications as and when required by state, regulatory agency, or hospital mandate .demonstrates knowledge of and adheres to, all applicable professional regulatory practice acts, state/federal regulations and policies and procedures of OVHD, including The Joint Commission, Title XXII and requirements of other regulatory agencies .ensures that each resident receives optimal nutritional care within set guidelines .interviews the resident and completes the appropriate screening, and history information .recommends nutrition treatment .intervention . The job description did not list qualifications from the pathways of the HSC 1265.4. 2. During an interview on 3/20/25 at 11:52 a.m. with RD 1, RD 1 stated she had been a remote full-time dietitian for the facility for approximately 3 years. RD 1 stated she was available Monday through Friday 8 a. m. to 5 p.m. for the facility via phone call, text, and email. RD 1 stated she did not perform her job duties on site. RD 1 stated she visited the facility once a year for approximately 2-5 days. RD 1 stated approximately 4/2024 was the last time she was onsite at the facility. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/21/25 at 8:44 a.m. with RD 1, RD 1 stated she completed admission nutrition assessments, annual and quarterly nutrition reports and nutrition focused physical examinations with the assistance of Certified Nursing Assistants (CNA) and Licensed Vocational Nurses (LVN). RD 1 stated, [CNA's and LVN's] are my eyes. RD 1 stated she reviewed CNA and LVN documentation for evidence of weight loss, weight gain, muscle wasting, bony prominences and frailness to complete nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports. RD 1 stated she called the nursing station and asked CNA's or LVN's if there was evidence of weight loss, weight gain, muscle wasting, bony prominences and frailness for each resident to complete nutrition focused physical examinations, admission assessments, annual and quarterly nutrition reports. RD 1 stated she relied on CNA's, LVN's, and the DM to complete nutritional assessments because she was not physically onsite and could not physically assess the resident. RD 1 stated, I rely on CNA's and LVN's to do the standard of practice of a focused nutritional assessment. RD 1 stated her nutritional assessment was a chart review and CNA's or LVN's completed the physical assessment. RD 1 stated she completed the documentation for all nutrition assessments. During an interview on 3/22/25 at 10:15 a.m. with the Director of Nursing (DON), the DON stated RD 1 was responsible to perform focused nutritional assessment on residents. The DON stated it was out of the professional scope for CNA's and LVN's to perform a focused nutrition assessment on a resident for RD 1. The DON stated CNA's and LVN's were not trained to perform a focused nutrition assessment. The DON stated she assumed RD 2 completed focused nutritional assessments and all other assessments required for nutrition as she was on site once a week. The DON stated all residents in the facility were at risk for inaccurate assessments, weight loss, weight gain and nutritional deficiencies if RD 1 and RD 2 were not performing duties as assigned and according to standards of practice. During a review of RD 1's job description contract titled, Nutrition Consulting Services Agreement, dated 8/11/09 and signed by RD 1 on 8/21/09, the document indicated, .consultant is a registered dietician .and is qualified to provide nutrition consulting services and medical nutrition therapy to patients .provide nutritional consulting services .consultant shall comply with all policies and procedures of facility .the reporting of incidents affecting the quality of patient care, and the periodic reporting of specific quality control indicators . consultant agrees that all Nutrition Services provided by him/her shall meet or exceed the standards required by facility, including the standards of appropriate licensing agencies, including the State of California and the Joint Commission .on-going quality improvement monitoring activities, such as audits, which shall be conducted annually in the Facility in order to evaluate the appropriateness, timelines, and effectiveness of Nutrition Services provided and to evaluate and enhance the quality of patient care .facility shall employ sufficient support personnel competent to carry out the functions of the Program pursuant to Title 22, California Code of Regulations S72351 . During a review of the State requirements professional reference titled, Title 22 California Code of Regulations (CCR) Section S72351 Dietic Service Staff,, indicated, . (a) A registered dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service education programs. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of RD 1's most recent kitchen audit checklist titled, Sanitation and Food Safety Checklist, dated 6/30/21, the checklist indicated, RD 1 last completed a kitchen audit on 6/30/21 and not annually as outlined in the Nutrition Consulting Services Agreement. During a review of the Revised 2024 Scope and Standards of Practice for Registered Dietitian Nutritionist (RDN) from the Commission on Dietetic Registration the credentialing agency for the Academy of Nutrition and Dietetics, indicated RDNs (RDs) are the most qualified to provide Medical Nutrition Therapy (MNT), a cost-effective, essential component of comprehensive nutrition care. It indicated RDs in clinical practice provide person centered nutrition care and MNT use the Nutrition Care Process (NCP -NCP is a systematic problem-solving method that credentialed nutrition and dietetics practitioners use to critically think and make decisions when providing MNT or to address nutrition-related problems and provide safe and effective quality nutrition care. The NCP consists of four distinct, interrelated steps: Nutrition Assessment and Reassessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation). It indicated in Standard 7 (seven) providing person-/population-centered nutrition care, the registered dietitian nutritionist (RDN) conducts nutrition care process and workflow elements to identify and address nutrition-related problems which a RDN is responsible for treating. It indicated the RD: 7.2 Conducts nutrition assessment. 7.2.5 Obtains and assesses findings from nutrition-focused physical exam (NFPE).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure food was stored, and served safely in accordance with professional standards of food service safety for 91 out of 91 residents eating at the facility when: 1. An individually wrapped tuna sandwich was expired in the nourishment refrigerator. This failure had the potential to result in the serving of an expired tuna sandwich to 35 out of 35 residents eating regular textured diets at the facility which had the potential to lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). 2. A bottle of wine was not labeled and dated in the resident refrigerator. This failure resulted in the facility not labeling and dating a personal food item per policy for one resident (Resident 28) which had the potential to lead to the growth of microorganisms and result in food borne illness. Findings: 1.During a concurrent observation and interview on [DATE] at 10:15 a.m. with the Dietary Manager (DM) in the nourishment refrigerator, an individually wrapped tuna sandwich was observed labeled, Tuna ,d+[DATE]-, d+[DATE]. The DM stated the tuna sandwich was expired and should have been removed on [DATE] by a dietary aide. The DM stated an expired tuna sandwich could result in foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) if consumed by a resident. The DM stated kitchen staff should stock, clean and remove expired food items from the nourishment refrigerator every morning and evening. The DM stated there was no log, record or checklist kitchen staff completed after performing these tasks. The DM stated she did not assign dietary aides to these tasks. The DM stated these tasks were competed by the first available dietary aide in the morning and evening. The DM stated it was her responsibility to ensure kitchen staff completed their assigned tasks. During an interview on [DATE] at 2:55 p.m. with Registered Dietician (RD) 2, RD 2 stated kitchen staff were responsible to maintain the nourishment refrigerator. RD 2 stated there was no log, record or checklist kitchen staff completed after performing these tasks. RD 2 stated she expected kitchen staff to remove expired food items from the nourishment refrigerator. RD 2 stated all residents with a regular diet texture were at risk for receiving an expired tuna sandwich from the nourishment refrigerator. RD 2 stated an expired tuna sandwich could result in foodborne illness (illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) if consumed. RD 2 stated foodborne illness could make residents sick and cause nausea, vomiting and diarrhea. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 10:15 a.m. with the Director of Nursing (DON), the DON stated she expected all expired food items to be removed from the nourishment refrigerator by kitchen staff. The DON stated kitchen staff were responsible to stock, clean and remove expired food items twice a day from the nourishment refrigerator. The DON stated all residents eating a regular texture diet within the facility were at risk for foodborne illness if they ate the sandwich. During a review on the facility's recipe titled, Tuna Salad Sandwich, undated, the recipe indicated, the tuna salad sandwich was made with chilled mayonnaise. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Length of Storage of Foods, dated ,d+[DATE], the P&P indicated, .it is the policy . that food products be stored in a safe manner to prevent food-borne illnesses .length of storage of foods is correlated to food safety .potentially hazardous foods that have been prepared or cooked will have a three day expiration date .examples are the following . salads with mayonnaise . 2.During a review of Resident 28's Admission Record (AR- document containing resident personal information), dated [DATE], the AR indicated, Resident 28 was admitted to the facility on [DATE] During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool) assessment, dated [DATE], the MDS assessment indicated Resident 28's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 13 out of 15 which indicated Resident 28 had no cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a concurrent observation and interview on [DATE] at 10:15 a.m. with the Dietary Manager (DM) in the resident refrigerator, a small bottle of wine was observed with Resident 28's name and room number. No received date was observed on the bottle of wine. The DM stated the bottle of wine was a personal food item. The DM stated all personal food items were expected to have the residents name, room number and received date. The DM stated she did not observe a received date or a manufacture expiration date on the bottle of wine. The DM stated it was important to label personal food items with a received date to determine expiration. The DM stated there was no way to determine how long the wine bottle was stored in the resident refrigerator or when it expired with no received date or manufacture expiration date. The DM stated it was facility policy to keep all personal food items for three days from the received date and then discard the food item. The DM stated Resident 28 was at risk for foodborne illness if the wine bottle was expired and she consumed the beverage. During an interview on [DATE] at 2:55 p.m. with Registered Dietician (RD) 2, RD 2 stated it was kitchen and nursing staff responsibility to maintain the resident refrigerator. RD 2 stated nursing staff were responsible to label all food from an outside source with the resident's name, room number and received date. RD 2 stated it was important to include the received date on the personal food item label to ensure food items were discarded after three days. RD 2 stated received date labels ensure food items without a manufacture expiration date are discarded after 3 days. RD 2 stated without a received date label on Resident 28's food item she could not determine an expiration date and could not determine if the food item was expired. RD 2 stated labeling food items ensured Resident 28 would not consume an expired food item. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 4:51 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 Stated it was the responsibility of all nursing and kitchen staff to ensure food items were labeled per facility policy. CNA 7 stated it was the responsibility of the staff member who received the wine bottle to label the food item with the received date. CNA 7 stated all food items that were not labeled with the resident's name, room number and received date should be discarded to prevent serving an expired food item. CNA 7 stated the resident refrigerator was reviewed daily to ensure all foods were discarded in a timely manner. CNA 7 stated there was no log, record or checklist to ensure who reviewed the resident refrigerator. During an interview on [DATE] at 9:22 a.m. with Resident 28 in Resident 28's room, Resident 28 stated she had not had wine in a long time and could not remember when the wine was brought into the facility. During a concurrent interview and record review on [DATE] at 10:15 a.m. with the Director of Nursing (DON), a picture of Resident 28's wine bottle, dated [DATE] was reviewed. The DON stated the wine bottle had no received date or manufacture expiration date. The DON stated she expected all personal food items to be labeled with the resident name, room number and received date, per facility policy. The DON stated the received dated determined an expiration date in the absence of a manufacture expiration date. The DON stated all personal food items were discarded three days after the received date to avoid serving expired food items. The DON stated Resident 28 was at risk for receiving an expired food item which could lead to food borne illness. During a review of the facility's P&P titled, Food from Outside Sources, dated ,d+[DATE], the P&P indicated, food left in the resident's refrigerator shall be labeled with the resident's name and date .food items will be discarded after three (3) days .the night shift .staff member assigned to check the refrigerator shall discard all out-of-date foods . During a review of the facility's job description document titled, Nutrition and Food Services Aide I, dated [DATE], the document indicated, .prepares and delivers nourishment's to the proper locations, maintaining nourishment stock levels in utility refrigerators at various nursing units .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview and record review, the facility failed to maintain a clean and sanitary environment for four of 24 sampled residents (Residents 62, 65, 80 and 88) when: 1.Resident 88 had a urinal (a container, often a bottle, used for collecting urine, typically for someone who is unable to get out of bed to use a regular toilet), filled with urine, on his bedside table (serve as a surface for food trays and can hold personal items such as phones, laptops, or books) next to drinking cups, protein shakes and medication in a medicine cup. This failure placed Resident 88 at risk for cross-contamination (the unintentional transfer of harmful substances from one person, object, or place to another) which could result in infections and illness. 2.Licensed Vocational Nurse (LVN) 2 did not clean and disinfect the glucometer machine (a portable device used to measure blood sugar) after using for Residents 62 and 80. This failure had the potential risk in the development and transmission of communicable diseases and infections for Residents 62 and 80. 3. Nursing staff did not wear gloves or a gown during direct patient care to Resident 65 while Resident 65 was on on Enhanced Barrier Precaution (EBP-infection control interventions, primarily used in long-term care facilities, that involve targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs). This failure resulted in the risk for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and the spread of infection. Findings: 1. During a review of Resident 88's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/21/25, the Face Sheet indicated, Resident 88 was admitted to the facility on [DATE]. During a review of Resident 88's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/28/25, the MDS assessment indicated Resident 88's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 88 was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 88's Medical Diagnosis (MD), dated 3/21/25, the MD indicated Resident 88 was diagnosed with sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), cellulitis (a bacterial infection of the skin and the tissues just beneath it) of the right lower leg, chronic kidney disease (damage and loss of function in the kidneys) and anxiety (a feeling of worry, nervousness, or fear, often about things that might happen, and it can involve physical symptoms like a racing heart or sweating). During an observation on 3/18/25 at 1:05 p.m., in Resident 88's room, there was a urinal filled with urine sitting on his bedside table next to drinking cups, protein shakes and medication in a medicine cup. Resident 88 stated the urine had been there awhile. During an interview on 3/20/25 at 2:42 p.m., with the Assistant Director of Nursing (ADON), the ADON stated there should not have been urine in a urinal on Resident 88's bedside table. The ADON stated his urinal should have never been next too food or shakes. The ADON stated cross-contamination of bacteria (tiny organisms, or living things, that can cause disease) could have occurred. The ADON stated the facility policy and procedure (P&P) Standard Precautions was not followed by staff. During an interview on 3/21/25 at 9:55 a.m., with the Infection Preventionist (IP), the IP stated Resident 88's urinal should not have been on the bedside table. The IP stated Resident 88 eats off of his bedside table and a urinal there would be a big no-no. The IP stated Resident 88 could have bacteria in his urine that could make it contagious (bacteria that can be transmitted or passed on from one person to another). The IP stated cross-contamination could have occurred and the urinal could splash urine onto his drinking cups, protein drinks, or medication and make him sick. The IP stated the facility P&P Standard Precautions was not followed by staff. During an interview on 3/21/25 at 2:20 p.m., with Certified Nursing Assistant (CNA) 8, CNA 8 stated urinals should be hung off the resident bed away from food and drinks. CNA 8 stated germs (tiny organisms, or living things, that can cause disease or sickness) could get on a person's food with the urinal so close to it and could have caused an infection for Resident 88. During an interview on 3/22/25 at 9:38 a.m., with Registered Nurse (RN) 1, RN 1 stated she was the nurse for Resident 88 when the urinal was observed on the bedside table filled with urine. RN 1 stated that urinal should never have been on that table. RN 1 stated she, or a CNA, should have emptied the urinal and moved it off of the bedside table. RN 1 stated this was a major infection risk because urine should never be next to food and cups that the resident was using. During an interview on 3/22/25 at 10:15 a.m., with the Director of Nursing (DON), the DON stated the urine on the bedside table was an infection issue. The DON stated urine mixed with food would equate to a low quality of life for Resident 88. The DON stated the urine could have spilled on the floor and caused a safety hazard. The DON stated this issue put Resident 88 at risk for infection and he even could have drank the urine by accident. The DON stated the facility staff did not follow the P&P Standard Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Standard Precautions, dated May 2024, the P&P indicated, . [Facility name] applies standard precautions to all patients regardless of their diagnosis or presumed infection status .PURPOSE: to provide guidelines on implementing standard precautions, which are the minimum infection prevention practices designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources. They are applied to all patients, regardless of suspected or confirmed infection status, in any setting where health care is delivered . Standard precautions our practices used to reduce healthcare associated infections and all healthcare settings, and they are applied when interacting with . body fluids, secretions, excretions Patient-Care Equipment and Surface Detection: handle used patient care equipment soiled with . body fluids, secretions and excretions any manner that prevents skin and mucous membrane exposure, contamination of clothing and transfer of microorganisms to other patients and environments . Environmental Control: ensure adequate cleaning and disinfecting procedures for environmental surfaces . bedside equipment and other frequently highly touched surfaces . 51345 2. During a concurrent observation and interview on 3/19/25 at 10:48 a.m. with LVN 2, LVN 2 used [brand name] disinfecting wipe (germicidal disposable wipe) in cleaning and disinfecting the glucometer machine after taking the blood sugar of Resident 62. LVN 2 wiped the glucometer machine from front to back for two seconds, placed the glucometer machine on top of the medication cart without a barrier, and air dried for one minute. LVN 2 stated, . It's been two minutes, it was dry. During concurrent observation and interview on 3/19/25 at 10:50 a.m. with LVN 2, LVN 2 placed the glucometer machine at the medication cart without a barrier after taking the blood sugar of Resident 80. LVN 2 used [brand name] wipe in cleaning and disinfecting the glucometer machine after taking the blood sugar of Resident 62. LVN 2 wiped the glucometer machine from front to back for five seconds, placed the glucometer machine on top of the medication cart without a barrier, and air dried for two minutes. During an interview on 3/20/25 at 2:45 p.m. with the IP, the IP stated they follow the facility's P&P for cleaning and disinfecting of the glucometer machine. The IP stated, [brand name] wipe purple top are used in cleaning and disinfecting glucometer machine and stated, . let it dry naturally for two minutes. The IP was confused with the word kill time/wet time, and stated, I need to review our P&P. The IP stated nurses should place a barrier on top of medication cart before placing the used glucometer machine. The IP stated the glucometer machine was considered contaminated with blood. The IP stated, ' . very important to clean and disinfect the glucometer machine for 2 minutes to prevent cross contamination and infection. The IP was not aware of [brand name] wipe's manufacturer's guidelines. During an interview on 3/21/25 at 11:57 a.m. with the Director of Nursing (DON), the DON stated cleaning and disinfection of glucometer machine required the use of Sani wipe for two minutes. The DON stated she was not aware and trained on properly disinfecting the glucometer machines based on manufacture's guidelines. The DON stated if the glucometer machine was not wet for two minutes, the potential risk for infection is high. The DON stated, .upon reading the Sani wipes manufacture's guidelines, the facility training we received was not accurate. The DON stated, .I need to review again our policy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the review of facility's P&P titled, Steps for Monitoring Glucometer, unknown date, the P&P indicated, . clean the glucometer with Sani wipe from back to front as instructed by the manufacturer and put it on another clean paper towel .once glucometer is dried after 2 minutes kill time/wet time . During a review of manufacture's guidelines titled, [brand name]-Cloth Germicidal Disposable Wipe, the manufacturer guidelines indicated, Contact time: Use second germicidal wipe to thoroughly wet surface. Allow surface to remain wet two (2) minutes, let air dry. During a review of facility's Policy and Procedure (P&P) titled, Standard Precautions, revised 1/12/2017, the P&P indicated, applies Standard Precaution to all patients regardless of their diagnosis or presumed infection status. Standard precautions are practices used to reduce healthcare associated infections in all health care settings, and are applied when interacting with blood, body fluids, secretions, excretions (except sweat), regardless of whether they contain visible blood, non-intact skin and mucous membranes. Procedure:5. Patient-Care Equipment and Surface Disinfection a. Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretion in a manner that prevent skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other patients and environment, 6. Environmental Control a. Ensure adequate cleaning and disinfecting procedure for environmental surfaces, . bedside equipment, and other frequently high touch surface with a hospital approved disinfectant. 51059 3. During a review of Resident 65's Admission Record (AR- document containing resident personal information), dated 3/22/25, the AR indicated, Resident 65 was admitted to the facility on [DATE] with diagnosis which included acute respiratory failure with hypoxia (occurs when the lungs fail to adequately oxygenate the blood, leading to dangerously low oxygen levels in the blood [hypoxia]), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs. The damage results in swelling and irritation, also called inflammation, inside the airways), anemia (a condition where your blood doesn't have enough healthy red blood cells to carry adequate oxygen to your body's tissues, leading to symptoms like fatigue, weakness, and shortness of breath.) and diastolic heart failure (occurs when the heart's left ventricle stiffens and can't relax properly between beats, preventing it from filling with enough blood, leading to reduced blood flow) During a review of Resident 65's Minimum Data Set (MDS- a resident assessment tool) assessment, dated 1/31/25, the MDS assessment indicated Resident 65's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 00 out of 15 which indicated Resident 65 had severe cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During an observation on 3/21/25 at 5:25 p.m. outside of Resident 65's room, there was an orange dot and an EBP sign next to Resident 65's name. The Director of Staff Development (DSD) 1 was observed entering the room with no gloves or gown. The DSD 1 placed a towel over Resident 65's chest, touched the bed with her body while leaning over Resident 65, and repositioned a pillow under Resident 65's legs. The DSD 1 exited Resident 65's room, performed hand hygiene and walked to the nursing station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/25 at 5:32 p.m. with the DSD 1, the DSD 1 stated she was a Licensed Vocational Nurse (LVN). The DSD 1 stated Resident 65 was on Enhanced Barrier Precaution (EBP) for Methicillin-Resistant Staphylococcus aureus (MRSA - a type of bacteria that's developed resistance to antibiotics and can cause infections, it is spread through direct contact). in her urine. The DSD 1 stated it was a standard of practice and facility policy to wear a gown and gloves when providing direct care to residents on EBP's to prevent the spread of infection. The DSD 1 stated she entered Resident 65's room to prepare Resident 65 for dinner. The DSD 1 stated she was not wearing a gown or gloves when she placed a towel over Resident 65's chest, touched the bed with her body while leaning over Resident 65, and repositioned a pillow under Resident 65's legs. The DSD 1 stated she exited Resident 65's room, performed hand hygiene, and planned to leave the hallway as there were no more meal trays to distribute. The DSD 1 stated not wearing a gown or gloves placed all other residents within the facility at risk for MRSA. The DSD 1 stated EBP's were in place to prevent the risk of cross contamination and the spread of infection. During a concurrent observation and interview on 3/21/25 at 5:38 p.m. with DSD 1, Resident 65's dinner tray was delivered to Resident 65's room by Certified Nursing Assistant (CNA) 4. CNA 4 entered Resident 65's room with no gown or gloves. CNA 4 touched Resident 65's bedside table and meal tray with no gloves or gown. CNA 4 positioned Resident 65's bedside chair next to Resident 65's bed with no gloves or gown. CNA 4 sat beside Resident 65's bed with no gloves or gown and fed Resident 65. CNA 4 was observed touching Resident 65's bed with her right leg and right elbow. CNA 4 was observed feeding Resident 65 with no gloves and continuously leaned over Resident 65. The DSD 1 stated she observed CNA 4 with no gloves or gown and touching Resident 65's while providing direct care. The DSD 1 stated CNA 4 should have placed gloves and a gown on to provide direct care and prevent the risk of cross contamination. During an interview on 3/21/25 at 5:43 p.m. with Registered Nurse (RN) 2, RN 2 stated Resident 65 was on EBP for MRSA in her urine. RN 2 stated all staff were expected to wear gloves and a gown when providing direct care. RN 2 stated assisting a resident for meal set up and feeding was direct care. RN 2 stated not wearing a gown or gloves when providing direct care was an infection control issue and placed every resident in the facility at risk for infection. During a concurrent interview and record review on 3/21/25 at 6:05 p.m. with the Infection Preventionist (IP), the facility Enhanced Barrier Precaution Binder dated 3/19/25 was reviewed. The IP stated Resident 65 was on EBP for MRSA in the urine. The IP stated she expected all staff to wear a gown and gloves when providing direct care or touching the environment of a resident on EBP. The IP stated all residents on EBP had an orange dot next to their name and posted EBP signage at the door. The IP stated all staff were trained on orientation and annually on EBP and how to identify residents on EBP. The IP stated she expected all staff to wear a gown and gloves when touching Resident 65 and Resident 65's belongings to prevent the spread of infection to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/22/25 at 10:15 a.m. with the Director of Nursing (DON), Resident 65's Laboratory Report dated 2/16/23 was reviewed. The DON stated Resident 65 had been on EBP for MRSA in the urine since 2/16/23. The DON stated MRSA in the urine was a multidrug -resistant organism (MDROs- bacteria or other microorganisms that have become resistant to one or more classes of antimicrobial agents, making infections they cause difficult to treat). The DON stated it was facility policy to place all residents with a history of MDRO on EBP to prevent the spread of infection and cross contamination to other residents. The DON stated she expected all staff to wear a gown and gloves when providing direct care to residents on EBP's. The DON stated it was facility policy to wear a gown and gloves when providing high-contact resident care activities to residents on EBP's. The DON stated meal set up and feeding was direct care and was an example of a high-contact resident care activity. The DON stated DSD 1 and CNA 4 did not follow facility policy when providing direct care to Resident 65. The DON stated she expected all staff to follow facility policy and infection control standards of practice. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 9/2024, the P&P indicated, .it is the policy of Oakdale Nursing & Rehabilitation Center facility to implement a process to evaluate the facility and individual resident risk for multidrug-resistant organism (MDROs) and implement interventions to reduce transmission of MDROs to other staff and residents . Enhanced Barrier Precautions (EBP): refer to an infection control intervention designed to reduce transmission of targeted MDROs that employs targeted gown and glove use during high contact resident care activities. EBP is used in conjunction with standard precautions and expands the use of personal protective equipment (PPE) to donning of gowns and gloves during high-contact resident care activities .EBP is to be used for residents with a history of targeted MDROs .High Contact Activity: activities that have been demonstrated to result in transfer of MDROs to hands and clothing of healthcare personnel and occur in the resident's room . During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Plan, dated 8/2020, the P&P indicated, .prevent and/or reduce healthcare associated infections by maintain practices that have the potential to reduce healthcare associated infections minimizing the risk of transmitting infections by implementing appropriate precautions . During a review of the facility's job description document titled, Certified Nursing Assistant I, dated 9/13/23, the document indicated, .performs general care activities for patients/residents .in according to Infection Control policies . During a review of the facility's job description document titled, Licensed Vocational Nurse I, 9/13/23, the document indicated, .practices universal precautions while providing care . (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Centers for Disease Control and Prevention article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, the article indicated, .Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality . Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities . Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing . The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with .MDRO infection or colonization .